Case History

Name ______ Date ______

Address ______ City ______ State ______ Zip ______ E-Mail Address ______

H. Phone (___) ______ W. Phone ______ Cell Phone No. ______ Date of Birth ______ (Age____)

Referred by ______

Occupation ______ Employer ______

Marital Status S M D W Spouse's Name ______

Spouse's Occupation ______ Number of Children and Ages ______

Have you ever received Chiropractic Care? ☐ Yes ☐ No

Social Security Number ______

Driver's License Number ______

Present complaint (be brief) ______

Major ______

Pain or problem started on ______

Pains are ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

What activities aggravate your condition/pain? ______

What activities lessen your condition/pain? ______

Is condition worse during certain times of the day? ______

Is this condition interfering with work? ______ Sleep? ______ Routine? ______ Other? ______

Is condition getting progressively worse? ______

Other Doctors seen for this condition ______

Any home remedies? ______

- ☐ Headache
- ☐ Neck Pain
- ☐ Sleeping Problems
- ☐ Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Face Flushed
- ☐ Neck Stiff
- ☐ Menstrual Problems
- ☐ Jaw Pain
- ☐ Wrist Pain
- ☐ Pins & Needles in Legs
- ☐ Pins & Needles in Arms
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Lights Bother Eyes
- ☐ Loss of Memory
- ☐ Ears Ring
- ☐ Fever
- ☐ Reproductive Problems
- ☐ Knee Pain
- ☐ Foot Pain
- ☐ Fainting
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Hands Cold
- ☐ Stomach Upset
- ☐ Constipation
- ☐ Cold Sweats
- ☐ Loss of Balance
- ☐ Buzzing in Ears
- ☐ Shoulder Pain
- ☐ Elbow Pain

Are you currently under medical care? ______

Have you been under drug and medical care? ______

What medications are you taking? ____________________

How Long? __________ Have you had surgery? __________ What? ____________________ When? __________

What side effects have you experienced from the drugs and surgery? ____________________

What nutritional products are you taking? ____________________

Is there a family history of

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side	☐	☐	☐	☐	☐ __________
Mother's Side	☐	☐	☐	☐	☐ __________

Have you been in an accident? ☐ Yes ☐ No

☐ Work ☐ Auto ☐ Other Date __________ Nature of accident ____________________

Did you feel a popping or tearing noise in your neck of back? __________ Explain ____________________

Where? ____________________ When? __________ Were X-rays taken? __________

Have you lost days at work? __________ Date ____________________

Is insurance involved? __________ Which company? __________ Address ____________________

Attorney's name, if any ____________________ Claim # __________

Comments (Office use only) ____________________

____

____

Yes	No		Patient Comment If Answer is Yes	Chiropractor's Comments
☐	☐	Were you taught proper body movement and care?		
☐	☐	Did/do you smoke?		
☐	☐	Did/do you drink any alcohol?		
☐	☐	Diet (Do you eat healthy foods?)		
☐	☐	Have you been in accidents?		
☐	☐	Have you had surgery and organs removed/replaced?		
☐	☐	Drugs? (Prescriptive or non-prescriptive)		
☐	☐	Teeth problems?		
☐	☐	Eye problems?		
☐	☐	Hearing problems?		
☐	☐	Exercise regularly?		
☐	☐	Sleeping habits (nightmares?)		
☐	☐	Did/do you have occupational stress?		
☐	☐	Physical stress?		
☐	☐	Mental stress?		
☐	☐	Hobbies/Sports injuries		
☐	☐	Other traumas or problems		
		Sleeping posture Side ☐ Stomach ☐ Back ☐		
☐	☐	Allergies __________		

About your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.